INTAKE FORM - *(Please use back of page for additional space if needed to complete answers)*

Name:_____ Referred by:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Ph:_____ Cell:_____ Date of Birth:_____

E-mail:_____Occupation:_____

Emergency Contact:_____ Phone:_____

Intention for coming?

Are you currently under the care of any healthcare professional? Y__ N__ Please explain:_____

_____

Medications:_____

Accidents / falls? (include dates):_____

_____

Surgeries / Hospitalizations? (include dates):_____

_____

Any head, neck or back injuries?: _____

Do you suffer from frequent headaches? If so, explain: _____

Do you suffer from stress? (recent/chronic):_____

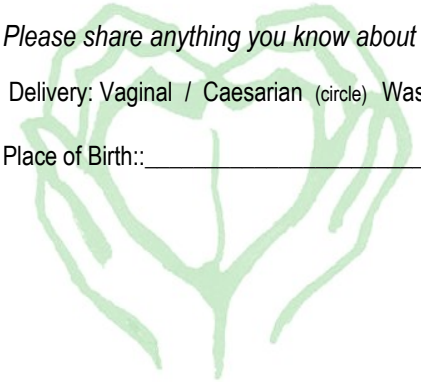
Briefly detail any trauma occurrence in your life (death, accidents, attack, etc.): _____

_____

Please share anything you know about your birth: Born in a hospital or at home? (circle) Bottle or breast fed? (circle)

Delivery: Vaginal / Caesarian (circle) Was your mother under anesthesia? _____ Did you spend time in an incubator? _____

Place of Birth::_____ *More details about your birth:*



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